DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1163 (Rev. 01/03)

WISCONSIN MEDICAID
SECOND OPINION ELECTIVE SURGERY REQUEST / PHYSICIAN REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: All Medicaid recipients, with the exception of recipients enrolled in a Medicaid HMO or in emergent, urgent, or waiver situations, are required to obtain a second surgical opinion (SSO) before having one of the surgical procedures listed in the Medicine and Surgery section of the Physician Services Handbook on an elective basis.

The ultimate responsibility for the decision to undergo or forego the proposed surgery remains with the recipient. The proposed surgery is reimbursable if the recipient decides to undergo the procedure, whether the second opinion physician agrees or disagrees with the recommending surgeon.

SECTION I — RECOMMENDING SURGEON INFORMATION

Date (MM/DD/YY)

Note: The recommending surgeon must complete Section I of the form before sending the form to the second opinion physician.

Check One
- ❑ I would like the second opinion physician to send this form back to me.
- ❑ I would like the second opinion physician to send this form directly to Wisconsin Medicaid.

Recipient (Patient) Information

Name — Recipient	Wisconsin Medicaid Identification Number (10 digits)	
Address (Street / P.O. Box)		
City	State	Zip Code
Telephone Number	County	
Birth Date (MM/DD/YY)	Gender ❑ Female ❑ Male	

Recommending Surgeon (mailing address)

Name — Recommending Surgeon	Wisconsin Medicaid Provider Number (eight digits)	
Address (Street)		
City	State	Zip Code
Telephone Number		

Specify whether someone other than the recipient (parent, relative, guardian, etc.) should be contacted concerning the second opinion.

Name — Contact Person	Telephone Number

Address (Street)

City	State	Zip Code

Primary / Referring Physician (if different from above)

Name — Primary / Referring Physician

Address (Street)

City	State	Zip Code

Check Proposed Procedure

- ❑ Cataract extraction and/or intraocular lens implant (❑ check if bilateral)
- ❑ Cholecystectomy
- ❑ D&C (diagnostic)
- ❑ Hemorrhoidectomy
- ❑ Hernia repair (❑ check if bilateral)
- ❑ Hysterectomy
- ❑ Joint replacement — hip (❑ check if bilateral)
- ❑ Joint replacement — knee (❑ check if bilateral)
- ❑ Tonsillectomy and/or adenoidectomy
- ❑ Varicose vein surgery

SIGNATURE — Recommending Surgeon	Date Signed

SECTION II — SECOND OPINION PHYSICIAN INFORMATION

Note: The physician performing the second opinion must complete this section of the form.

Name — Performing Physician	Wisconsin Medicaid Provider Number (eight digits)

Address (Street)

City	State	Zip Code

Findings (include any information on alternative treatment, additional medical tests, or other significant findings)

❑ These findings and options / alternatives were presented to the recipient.

Check One
- ❑ I agree with the need for the surgery.
- ❑ I do not agree with the need for the surgery.

Comments

SIGNATURE — Second Opinion Physician	Date Signed

Distribution: Following the recommending surgeon's request indicated on the front page, return this form to either the recommending surgeon whose name and address are listed on the front page, or mail to:

Wisconsin Medicaid
SSO Dept
6406 Bridge Rd
Madison WI 53784-0012

Reset Form